

**Medical Release and Contact Information**

General Information

Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Parent's Names: \_\_\_\_\_ & \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Work Phone 2: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_

Emergency Contact Information

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Contact #: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Contact #: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work  
Phone: \_\_\_\_\_ Work Phone 2: \_\_\_\_\_  
Doctor's Name: \_\_\_\_\_ Office #: \_\_\_\_\_  
Dentist's Name: \_\_\_\_\_ Office #: \_\_\_\_\_  
Other's Name: \_\_\_\_\_ Office #: \_\_\_\_\_  
Health Care Provider: \_\_\_\_\_ Plan # \_\_\_\_\_ Phone #: \_\_\_\_\_

Travel Information

Hotel Name \_\_\_\_\_ Hotel Phone \_\_\_\_\_ Room # \_\_\_\_\_

Liability Waiver and Medical Release

I agree that I shall provide health insurance to cover any personal injury sustained by the student and property damage while participating in any activities or while on the premises of the hockey camp provided by Altitude Hockey Camps, LLC; (the "Camp"). The undersigned assumes all responsibility for any and all risk for damage or injury that may occur to the above named player/s as a participant in the Camp, including practices, games, skill sessions, clinics, and other activities related to the Camp. In consideration of such, the undersigned hereby releases and discharge Altitude Hockey Camps, LLC, its members, owners, operators, employees, agents, supervisors, instructors and other players from all claims, demands, rights or cause of action present or future, whether known or anticipated and resulting from or arising out of or incident to the undersigned's participation with the said Camp. This is also my permission to have myself or my child admitted and attended to, for medical or dental treatment in case of sickness or injury.

\_\_\_\_\_  
Signature of parent or guardian / player (18 older) \_\_\_\_\_ Date

NOTE: This medical release is relative to scheduled Altitude Hockey Camps, LLC., activities in the event the parent(s)/ guardian are not present to assure medical treatment if necessary.

Medical History Allergies: \_\_\_\_\_  
Chronic Medical Problems: \_\_\_\_\_  
Medication/Treatment: \_\_\_\_\_  
Dietary Restrictions: \_\_\_\_\_

If the camper needs a prescribed medication during the camp, the following must be completed two weeks before the first day of camp: Written authorization signed by a parent or guardian, and written approval for the camp consultant to administer the medication.

I see no reason to restrict full participation in hockey camp. I certify that my child has not incurred any significant health problem(s) as of the date hereof.  
Parent's Signature: \_\_\_\_\_  
Date: \_\_\_\_\_  
Address \_\_\_\_\_